niques consist of testing for occult blood in a stool specimen, rectal examination and sigmoidoscopy.

To obtain a reasonable predictive value, proponents of fecal occult blood testing have recommended certain conditions, which have included the dietary deletion of red meat, vitamin C, peroxidase-rich vegetables and nonsteroidal anti-inflammatory medications. Some have recommended adding a high fiber content to the diet during the test period. Storing stool specimens for longer than four days increases the percentage of false-negatives. Rehydration of slides is no longer recommended because of the increased number of false-positives.

Even with these refinements, there have been critics of stool guaiac screening in asymptomatic patients. The American Cancer Society currently recommends two specimens from each of three separate bowel movements, with adherence to the dietary and storage restrictions. Two studies published in 1983 have reported that most colorectal carcinomas detected by stool guaiac testing were at Dukes' stage A or B. These figures are dramatic deviations from commonly reported prevalences of from 25% to 50% for these prognostically more favorable stages of the disease.

Sontag and co-workers found that 71% of cases of cancer detected by stool guaiac were Dukes' stage A or B. A nonscreened comparison group diagnosed during the same period were found to have advanced (Dukes' C or D) disease in 75% of the cases. Hardcastle and colleagues used a prospective randomized design. In the group accepting fecal occult blood testing, 91% (11 of 12) of cases of diagnosed colorectal carcinoma was diagnosed at stage A or B. In the year following the screening period, ten cases of colorectal carcinoma were diagnosed in the control group. Of these, 60% were stages C and D.

These studies support the American Cancer Society's screening recommendations for fecal occult blood. New developments include vegetable peroxidase inactivators by Helena Laboratories and Coloscreen pads. These may assist clinicians by diminishing the number of false-negatives and improving patient compliance. Available products and their costs have been recently reviewed.

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Anorexia Nervosa

THE *Diagnostic and Statistical Manual of Mental Disorders,* 3rd Edition, (DSM III) includes anorexia nervosa as one of the "eating disorders," along with bulimia, pica, rumination disorder of infancy and atypical eating disorder. Of these, anorexia nervosa has received greatest attention recently in the lay press. It is a disorder that is associated with dysfunction at the physiologic, psychologic, familial and social levels. Recent studies have provided new information on anorexia nervosa; that from family studies is particularly intriguing in regard to the development of treatment regimens.

It is estimated that as many as 1 in 250 young women between the high-risk ages of 12 and 18 years suffer from this disorder. Cases occur in both younger and older women; less than 5% of cases occur in men. Diagnostic criteria for anorexia nervosa include an intense fear of obesity unrelated to actual body habitus, disturbance of body image, weight loss of 25% or more of original or projected weight, refusal or inability to maintain body weight and an absence of any physical illness that might otherwise account for the symptoms. Most cases occur in women from middle- to upper-class families. Families of affected persons have been described as caricatures of "perfectly normal" families; members may be unaware of chronic emotional withdrawal and isolation. Minuchin and co-workers refer to these families as "psychosomatic families" and describe them as having the characteristics of enmeshment, overprotectiveness, rigidity and an inability to tolerate or resolve conflict. Advocates of family systems approaches comment on the central and regulatory role the anorectic symptoms play in the family.

Treatment of anorexia nervosa is contingent on recognition. Management should be by physicians willing to commit themselves to involvement in a complex, difficult and sometimes frustrating disorder. Clinical approaches must be based on a certainty, shared by clinicians and family members, that weight loss beyond a medically determined level will result in admission to hospital, despite resistances encountered from the patient or her family. Tube feeding, not innocuous, is occasionally required. Physicians must insure that they are not deceived by the ruses of patients. Psychiatrists or family systems-oriented therapists with experience in the management of this disorder should be involved as early as possible. Families and individuals are often strikingly resistant to change; resolving the problem frequently involves uncovering previously denied family pathology and successfully dealing with it. Treatment and support may be required on a long-term basis. Primary care physicians and therapists must communicate openly and regularly; this is especially critical in the early months of care. As gains are made in patient weight and family function, contacts for support may be carefully spaced; physicians must recognize the potential for both early and late recurrence and for the emergence of psychosomatic problems in other family members.

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